DBHDS INSTRUCTION

I. Purpose.

To establish a systematic process for tracking individuals with developmental disabilities who are under the age of 22 and seeking or currently receiving residential support in a private intermediate care facility, conducting annual Level of Care Reviews and providing information and education to families related to more integrated options.

II. Definitions.

a. **Children-**This means individuals under 22 years of age
b. **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)-** An ICF/IID is a facility, of no less than four (4) beds, that meets Federal Conditions of Participation and has as its primary purpose the provision of health or rehabilitation services to individuals with developmental disabilities or related conditions receiving care services under the Medicaid program.
c. **Community Transition Team for Intermediate Care Facilities (CTT-ICF)-** This means the designated members of the Community Integration Project Team who are assigned to work with private Intermediate Care Facilities supporting individuals under the age of 22 with developmental disabilities. The team is comprised of a Community Integration Manager and two-Family Resource Consultants.
d. **Community Integration Manager (CIM)**: This means the central office position that is responsible for coordinating the implementation of policies, procedures, regulations and other initiatives related to ensuring tracking, reviewing and providing education to families of children seeking admission or residing in an Intermediate Care Facility.
e. **Family Resource Consultant (FRC):** This means the central office position that is responsible for providing education and information to families, community residential providers and other stakeholders regarding Medicaid Waiver Services and community resources available to support individuals with developmental disabilities and their families.
f. **Reviewer**-This means the member of the Community Transition Team who is responsible for conducting a Level of Care Review.
g. **Level of Care (LOC) Review-**This means the onsite and record reviews of children in Intermediate Care/Institute for Intellectual Disability (ICF/IID) facilities. Under 42 CFR 456.360, certification and recertification must verify the individuals need for ICF services. The certification must be made at the time of admission and before the State

Medicaid agency authorizes payment. Recertification verifies the continued need of the individual for those ICF/IID services.

h. Memorandum of Understanding (MOU) - This means the modification of Interagency Agreement No. 137-09 which outlines DBHDS and DMAS responsibilities related to the implementation of Intermediate Care Facility beneficiary review responsibilities for children ages 0-21.

i. Community Services Board (CSB): This means the public body established pursuant to §37.2-501 or §37.2-602 of the Code of Virginia that serves the area in which a minor's parent or guardian resides, and that may provide support coordination and discharge planning support to a child living in an Intermediate Care Facility.

j. DMAS Quality Review Tool- This is the document developed by the Department of Medical Assistance Services (DMAS) for use during Level of Care Reviews to ensure children continue to meet the criteria for institutional placement, ICF teams make comprehensive medical, social and psychological evaluations (42CFR456.370); and children have plans of care that address their needs, have appropriate outcomes and have required reviews (42CFR456.380).

k. Personal Support Team (PST): This means a team, formally known as an interdisciplinary team (IDT), of professionals, paraprofessionals, and non-professionals who possess the knowledge, skills, and expertise necessary to accurately identify a specific individual's comprehensive array of needs and design a program that is responsive to those needs. At a minimum, the PST includes the child, Authorized Representative (AR), CSB support coordinator (if assigned), and other invited members of the individual's interdisciplinary team or those involved in the individual's life.

l. Active Discharge Process: This is when the PST, including the AR and child, are meeting and actively working on a plan to transition the child to a less restrictive setting within the next 3-6 months.

III. Procedures:

A. Census

i. A designated member of the Community Transition Team (CTT-ICF) will maintain regular contact with the ICF Social Worker and maintain a Tracking Log of all children residing in a private ICF. CTT-ICF will prioritize children for discharge planning based on the following criteria:

a. Children 10 years and under

b. Children with families, authorized representatives or guardians who would like to explore community residential options

c. Children residing in the facility for 6 months or less
d. Children in foster care or in court ordered placement, when requested and
e. Children between the ages of 18 and 21 years of age

B. **Level of Care Reviews (LOC)**

i. A designated member of the CTT will conduct annual Level of Care (LOC) Reviews utilizing the DMAS Quality Review Tool. LOC reviews will be conducted annually and, when possible, scheduled 60 days prior to the child's ICF annual review in an effort to:
   a. Promote discussion related to discharge and community integration.
   b. Provide the facility personal support team with information and/or recommendations to share with the family regarding community integration and residential options; and,
   c. Assist the facility in preparing for the current annual review by providing feedback regarding any deficiencies noted in prior assessments, certifications, the plan of care, etc.

ii. Written notice will be sent to the ICF at least 14 days prior to an LOC Review confirming the date, time and child to be reviewed. The completed review will be posted to the Community Integration Project Team (CIPT) shared drive. A letter containing review findings and recommendations from the CTT will be sent to the ICF within 7 days. DBHDS will request a response to recommendations within six months following the LOC Review and provide feedback as needed.

*** A designated CTT member will forward any concerns to the Director of Community Integration.**

C. Family Contact

i. DBHDS provides a Community Transition Guide to families of children in nursing facilities and ICFs/IID. For those seeking ICF/IID placement, the Guide is provided when a request for a VIDES assessment is made and every 6 months thereafter. The Guide was designed to provide practical information to children and their families, who are preparing to make decisions related to the type of care that best suits their support needs or are planning to transition from various facilities (Intermediate Care Facilities – ICFs, Nursing Facilities – NF) to new homes in the community. The guide assists families in preparing to move to a new home through an explanation of

resources and services such as DD Waivers, CSBs, and the DBHDS Community Transition Team that can assist the family with the transition process.

ii. DBHDS will facilitate quarterly calls or face to face contacts with representatives or legal guardians of children 10 years and under

iii. Information regarding community services and supports along with contact information for the CTT-ICF will also be given to the ICF Social Worker (SW) to share with families:
   a. When an application for admission is received,
   b. At the time of admission, and
   c. At the annual review

iv. Members of the CTT-ICF will work with the ICF SW to facilitate additional communication with families. This may include arranging for meetings at the ICF, home visits or conference calls with CSBs, provider agencies or other stakeholders. Direct contact will be made at the request of the family or ICF SW.

v. The CTT-ICF will conduct information sessions for families at the two large ICFs. Topics will include Waiver services, community resources, community agencies, and other information related to supporting a child with developmental disabilities.

D. Community Services Board (CSB)

i. The CTT-ICF will work with the ICF SW to:
   a. Assist families in identifying and contacting the appropriate CSB to request services
   b. Encourage CSB participation in discharge planning for all children residing in an ICF
   c. Facilitate communication regarding the children's service and support needs and discharge planning goals
   d. A discharge awareness letter will be sent to the CSBs 120 days prior to an individual's discharge date or as soon as a family has expressed interest in discharge. The letter will provide the ICFs contact information and list resources in the community that should be explored.

E. Regional Support Team (RST)

i. Referrals to the appropriate RST will be made in accordance with established guidelines.

ii. The CTT-ICF will collaborate with the Community Services Board (CSB) to ensure the submission of an RST referral for cases meeting the following criteria:
   a. Difficulty finding services in the community within 3 months of receiving a slot.
   b. Choosing to move to a group home of five or more individuals.
   c. Choosing to move into a nursing home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).
   d. Pattern of repeatedly being removed from home

F. Reporting

i. An ICF Tracking Log will be maintained by the CTT which includes the following information for each child residing in an ICF as of January 1, 2017:
   a. Name
   b. Age
   c. Date of Birth
   d. Medicaid number
   e. Date of Admission
   f. ICF name and capacity
   g. Current length of stay
   h. Discharge date
   i. Age at discharge
   j. Total length of stay as of discharge date
   k. LOC Review dates and findings (compliance/non-compliance)
   l. Specific area of non-compliance

ii. The CTT will provide a cumulative and quarterly report by the 5th day of the month following the end of each quarter (April, July, October, January).

iii. DBHDS will begin tracking children residing in community ICFs beginning January 2017. Reports will include the number of annual reviews completed, number of family contacts regarding integration options, number of children residing in ICFs and the number of children discharged from ICFs during the reporting period.

iv. Data regarding barriers to discharge and RST will be reflected in the RST data.

G. Post Move Monitoring (PMM)

i. Members of the CTT-ICF will coordinate post move monitoring contacts with the Community Services Board Support Coordinator and/or other involved parties for

children discharged from ICF/IIDs to ensure services and supports are in place and there are no gaps in care.

ii. A PMM report will be developed and maintained.
iii. CTT-ICF will consult with the Health Support Network Team as needed to address issues related to medical and/or rehab supports.
iv. During the 90-Day PMM, CTT members will offer family members an opportunity to serve as a peer support to other families considering discharge from a facility.